1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07251

# CERTIFICATE OF DEATH

07230

1. **PLACE OF DEATH**
   a. COUNTY: Talbot
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: 1 week
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: TALBOT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt #2 Easton, Md. 20.1
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First AGNES Middle O. Last ANDERSON

4. **DATE OF DEATH**: Month 5 Day 21 Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/23/96

9. AGE (In years last birthday): 70 yrs.
   IF UNDER 1 YEAR: Months 10 Days 28
   IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: SEAMSTRESS

11. BIRTHPLACE (County & State, or foreign country): TALBOT COUNTY-MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL B. SKINNER

14. MOTHER'S MAIDEN NAME: HENRIETTA CALLAHAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-34-7556

17. **INFORMANT**: MISS MARIE H. ANDERSON Address: WASHINGTON, D.C.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Metastatic carcinoma of rectum
   154X
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b):
   DUE TO
   (c):
   INTERVAL BETWEEN ONSET AND DEATH (a):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 14 May, 19 22, to 21 May, 1967, that (I) (we) last saw the deceased alive on 21 May 1967, and that death occurred at 11 p M, from causes and on the date stated above.

22a. SIGNATURE: Thurston Harrison
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 22 May 67

22c. PHYSICIAN'S NAME (Type): THURSTON HARRISON

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: MAY 24. 1967

23c. NAME OF CEMETERY OR CREMATORY: WOODLAWN MEMORIAL PARK

23d. LOCATION (City or Town) (County) (State): EASTON TALBOT MD.

24. FUNERAL DIRECTOR: Elmer Clark ADDRESS: Easton Md

25a. REC'D BY REGISTRAR DATE: MAY 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

07252

## CERTIFICATE OF DEATH

07231

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Claiborne
   c. LENGTH OF STAY IN 1b: 40 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ----

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Claiborne
   d. STREET ADDRESS: ----
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: SAMUEL — Middle: CHAPLAN — Last: BULLEN

4. **DATE OF DEATH**: Month: May — Day: 24, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 18, 1883

9. AGE (In years last birthday): 84 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Ferry Boat

11. BIRTHPLACE (County & State, or foreign country): Anne Arnudel County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sanuel C. Bullen

14. MOTHER'S MAIDEN NAME: Susie Purdy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give wer or dates of service): ----

16. SOCIAL SECURITY NO.: 217-16-1511

17. INFORMANT Address: Mrs. Bertie S. Bullen, Claiborne, Maryland

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Some

DUE TO (b): Coronary Artery Heart Dis — 2 years

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from May 24, 1967 to May 24, 1967, that (I) ~~(we)~~ last saw the deceased alive on May 24, 1967, and that death occurred at 3:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-25-67

22c. PHYSICIAN'S NAME (Type): R. LANE WROTH, M. D.

22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

23d. LOCATION (City, town or county) (State): Easton, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Harrison Leonard St. Michaels, Md.

25a. REC'D BY REGISTRAR DATE: MAY 26 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07253 — 07232

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 haurs after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH** a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): EASTON, MD. — c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspitol, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institutian: Residence before admission) a. STATE: MARYLAND — b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): 20-1
d. ~~STREET ADDRESS~~: ST. MICHAELS, MD. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First EDWARD — Middle C — Last CHANNING
4. **DATE OF DEATH**: Month MAY — Day 30 — Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-02-03
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months ~~12~~ Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of wark dane during mast of working life, even if retired): Ret. Auto Parts
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, ar foreign country): NIAGARA FALLS, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELMER C. CHANNING
14. MOTHER'S MAIDEN NAME: GRACE LAHMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown): No — (If yes give war ar dates of service):
16. SOCIAL SECURITY NO.: 218-01-9524
17. INFORMANT Address: MRS. E.C. CHANNING, ST. MICHAELS, MD.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction sudden — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): atherosclerotic coronary
DUE TO (c): art d.
Conditions, if any, which gave rise ta immediate couse (a), stating the underlying couse last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture af injury in Port I ar Port II af item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Nat While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City ar tawn) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-30-67, 19__ ta 5-30, 19__, that (I) (we) last saw the deceased alive an 5-30 19 67 and that death occurred at 10:55 M, fram causes and an the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-30-67
22c. PHYSICIAN'S NAME (Type): Harry M Redser Jr
22d. ADDRESS: St Michaels md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: JUN 2, 1967
23c. NAME OF CEMETERY OR CREMATORY: OLIVET CEMETERY
23d. LOCATION (City or Tawn) (County) (State): ST. MICHAELS, MD.

24. FUNERAL DIRECTOR: Harrison & Leonard — ADDRESS: St. Michaels, Md
25a. REC'D BY REGISTRAR DATE: JUN 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

07254 07233

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 5yr.2Mo.28Da
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): HOUSE IN THE PINES-EASTON, MD.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 229 S. Washington St., 20.1
d. STREET ADDRESS: Easton, Maryland
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Edna — Middle: EBAUGH — Last: Clark

4. **DATE OF DEATH**: Month: 5 — Day: 9 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-30-1885

9. AGE (In years last birthday): 81 8/yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (County & State, or foreign country): BALTIMORE Co. MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: McKENDREY EBAUGH

14. MOTHER'S MAIDEN NAME: AGNES HOUCK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-46-0485

17. INFORMANT — Address: LAWRENCE E. BIRGE — EASTON, MD

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, osteoarthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July, 1963, to 9 May, 1967, that (I) (~~we~~) last saw the deceased alive on 9 May 1967, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Stephen P. Carney M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9 May 67

22c. PHYSICIAN'S NAME (Type): Stephen P. Carney, M.D.

22d. ADDRESS: P.O. Box 929, Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: MAY 12, 1967 — 23c. NAME OF CEMETERY OR CREMATORY: SPRINGHILL — 23d. LOCATION (City, town or county) (State): EASTON MD

24 FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Easton Md

25a. REC'D BY REGISTRAR — DATE: MAY 12 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07255 — 07234

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Caroline
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denton
   d. STREET ADDRESS: RFD #1
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Edna — Middle: L. — Last: Collins

4. **DATE OF DEATH**: Month: 5 — Day: 2 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Feb. 28, 1898

9. AGE (In years last birthday): 69 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Purnell Towers

14. MOTHER'S MAIDEN NAME: Jennie Todd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No

16. SOCIAL SECURITY NO.: -------

17. **INFORMANT** Address: T. Sidney Collins, Denton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Congestive heart failure — months
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Noturol couses [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Louis O Welty M.D.

EXAMINER'S NAME (Type): - WELTY

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)

22. **DATE SIGNED** 5-2-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 5, 1967

23c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery

23d. LOCATION (City or Town) (County) (State): Federalsburg, Caroline, Md.

24. FUNERAL DIRECTOR: Frampton Funeral Home — ADDRESS: Federalsburg Md

25a. REC'D BY REGISTRAR DATE: MAY 8 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07256 — 07235

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: TALBOT
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON MD
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: CAROLINE
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELY
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CALVIN Middle CORNELIUS Last COVINGTON

4. DATE OF DEATH: Month 5 Day 3 Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 22, 1904

9. AGE (In years last birthday): 63 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HENRY COVINGTON

14. MOTHER'S MAIDEN NAME: LILLIAN E. REED

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs. Calvin Covington, Ridgely Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
    PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH:
    Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
    ~~DUE TO~~ (b): Cerebral thrombosis
    DUE TO (c):

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (i) (this hospital) attended the deceased from _____, 19__, to _____, 19__, that (i) (we) last saw the deceased alive on May 1, 19 67, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature]

M.O. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: May 4 67

22c. PHYSICIAN'S NAME (Type): E-C-H Schmidt

22d. ADDRESS: Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 6, 1967

23c. NAME OF CEMETERY OR CREMATORY: Chesterfield

23d. LOCATION (City, town or county) (State): Centreville Md.

24. FUNERAL DIRECTOR: Virgil Moore & Son

ADDRESS: Denton

25a. REC'D BY REGISTRAR DATE: MAY 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07257

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07236

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Caroline
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg - Rural
   d. STREET ADDRESS: Smithville Road
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: David — Middle: Otis — Last: Dawson

4. **DATE OF DEATH**: Month: 5 — Day: 18 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 4-12-59

9. AGE (In years last birthday): 8 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Student

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Otis Dawson

14. MOTHER'S MAIDEN NAME: Blanche Wharton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. **INFORMANT** Address: J. Otis Dawson, Federalsburg, Md., RFD

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Intracranial Damage with internal — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): and External Hemorhage — minutes
DUE TO (c): Fracture of the skull — minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Ran out in front of oncoming automobile

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 3:50 p.m. 5/18/67

20d. INJURY OCCURRED While at work [X] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Morris ave

20f. (City or town) Federalsburg (County) Caroline (State) Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Harold B. Plummer M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Harold B. Plummer M.D.

Address (Street, city, town, or county): Preston Caroline Maryland

22. **DATE SIGNED**: 5/19/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery

23d. LOCATION (City or Town) Federalsburg, Maryland (County) (State)

24. FUNERAL DIRECTOR: J. J. Framptom and Son

ADDRESS: Framptom and Son, Federalsburg, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 1 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forwarded to the Chief Medicol Examiner's Office along with form P.M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07277

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07237

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Claymont, — 46.3
d. STREET ADDRESS: 2611 Lincoln Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mrs. — Middle: Rosa — Last: De Looper
4. DATE OF DEATH: Month: 5 — Day: 17 — Year: 1967

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 7-25-1884 | 82 yrs. | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home.
11. BIRTHPLACE (State or foreign country): Birmhiminghan Eng.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Harry ---- Clowes
14. MOTHER'S MAIDEN NAME: Elizabeth Frekelton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 163 07 1571
17. INFORMANT: Address: Claymont, Del. — D Eric R. Horton 2611 Lincoln Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pumonary Edema due to chronic — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b): congestive heart failure from Arteriosclero- — 4200
DUE TO (c): otic heart disease with hypertension. — ?10-15 yrs
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ? Hiatus "ernia" — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot I took charge of the remoins described obove, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion deoth resulted from: Notural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Harold B. Plummer M.D.
EXAMINER'S NAME (Type): Harold B. Plummer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 5/17/67

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 20, 1967 | Gracelawn Memorial Pk. | New Castle, Del. |

24. FUNERAL DIRECTOR: William E. Jones — ADDRESS: Lic. #2444 — William E. Jones Claymont, Del.
25a. REC'D BY REGISTRAR: DATE MAY 22 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07258 Item #2 see Birth Cer **CERTIFICATE OF DEATH** 07238

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON MD
c. LENGTH OF STAY IN 1b 1hr-30min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely 05.2
d. STREET ADDRESS R.F.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

78

3. NAME OF DECEASED (Type or print) First: Baby Middle: Boy Last: DYOTT
4. DATE OF DEATH Month: 5 Day: 2 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/2/67
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 1 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: SAMUEL LEE DYOTT
14. MOTHER'S MAIDEN NAME: CYNTHIA CAROL BISHOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity — INTERVAL BETWEEN ONSET AND DEATH Hours
776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) Premature Onset Labor — Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-2, 1967, to 5-2, 1967, that (I) (we) last saw the deceased alive on 5-2 1967, and that death occurred at 6:30 M, from the causes and on the date stated above.

22a. SIGNATURE Richard Tyson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED 5-5-67
22c. PHYSICIAN'S NAME (Type) RICHARD TYSON
22d. ADDRESS EASTON Md 21601

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF May 6, 1967
23c. NAME OF CEMETERY OR CREMATORY RIDGELY
23d. LOCATION (City, town or county) (State) RIDGELY, MD.

24. FUNERAL DIRECTOR Virgil Moore & Son
ADDRESS Denton
25a. REC'D BY REGISTRAR DATE MAY 11 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judy

7-22902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07253 — 07239

**1. PLACE OF DEATH**
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HILLSBORO
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: WILLIAM — Middle: BROWN — Last: EATON

**4. DATE OF DEATH**: Month: 5 — Day: 19 — Year: 1967

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | ☑ NEVER MARRIED | 1/29/11 | 56 yrs. | 3 | 20 | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY: HARDWARE
11. BIRTHPLACE (County & State, or foreign country): TALBOT COUNTY, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE HENRY EATON
14. MOTHER'S MAIDEN NAME: MARY EMMA BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service):
16. SOCIAL SECURITY NO.: 216-03-7436
17. INFORMANT: Address: MRS. W. BROWN EATON, SR. HILLSBORO, MD.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 14 May, 1967 to 19 May, 1967, that (I) (we) last saw the deceased alive on 19 May 1967, and that death occurred at 5:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Thurston Harrison — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 22 May 67
22c. PHYSICIAN'S NAME (Type): THURSTON HARRISON
22d. ADDRESS: Easton Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: MAY 22. 1967
23c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEMETERY
23d. LOCATION (City or Town) (County) (State): HILLSBORO CAROLINE MD.

24. FUNERAL DIRECTOR: Nelson Clark — ADDRESS: Easton Md
25a. REC'D BY REGISTRAR DATE: MAY 24 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07260

## CERTIFICATE OF DEATH

07240

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural St. Michaels
c. LENGTH OF STAY IN 1b: 11 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural St. Michaels.
d. STREET ADDRESS: 'Broadview'
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ralph — Middle: M — Last: Ferry

4. DATE OF DEATH: Month: May — Day: 23, — Year: 1967.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 14, 1888

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Aluminum Co.of A.

11. BIRTHPLACE (County & State, or foreign country): Pittsfield, Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred G. Ferry

14. MOTHER'S MAIDEN NAME: Emma Sizer.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 176-09-9736A

17. INFORMANT: Address: Mrs. R M Ferry St. Michaels, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Gastro Intestinal Bleeding, — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Arteriosclerosis — 4 years.
DUE TO (c): Carcinoma of Pancreas — 6 mos.
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 20 May, 1967 to 23 May, 1967, that (I) (we) last saw the deceased alive on 22 May 1967, and that death occurred at 4:00 P.M. from causes and on the date stated above.

22a. SIGNATURE: A. Paul Wroth, M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-23-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: May 23, 1967

23c. NAME OF CEMETERY OR CREMATORY: Pittsfield

23d. LOCATION (City or Town) (County) (State): Pit tsfield, Mass

24. FUNERAL DIRECTOR: Willis Bruce — ADDRESS: Easton, Md

25a. ACCEPTED BY REGISTRAR DATE: MAY 25 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07261

## CERTIFICATE OF DEATH

07241

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: QUEEN ANNE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Church Hill, Md.
d. STREET ADDRESS: Box 62
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

78

3. NAME OF DECEASED (Type or print): First SARAH Middle C Last Fleming

4. DATE OF DEATH: Month 5 Day 5 Year 1967

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-14-84
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: ×
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Seward
14. MOTHER'S MAIDEN NAME: Margaret Frank

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Alton Scott - Church Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
330X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-5, 1967 to 5-5, 1967, that (I) (we) last saw the deceased alive on 5-5 1967, and that death occurred at 330 P.M., from causes and on the date stated above.

22a. SIGNATURE: S P Carney — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-8-67
22c. PHYSICIAN'S NAME (Type): S. P. Carney M.D.
22d. ADDRESS: Easton, Maryland 5/8/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAY 8
23c. NAME OF CEMETERY OR CREMATORY: CHURCH HILL
23d. LOCATION (City or Town) (County) (State): CHURCH HILL MARYLAND

24. FUNERAL DIRECTOR: Edgar L. Lane — ADDRESS: Church Hill Md.
25a. REC'D BY REGISTRAR DATE: MAY 11 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07262

# CERTIFICATE OF DEATH

07242

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 3 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Annes
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville
d. STREET ADDRESS: Railroad Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Virgil Middle: Raymond Last: Freeny
4. DATE OF DEATH: Month: 5 Day: 15 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: June 22, 1898
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Representative
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (County & State, or foreign country): Pittsville, Wicomico Co, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Richard Freeny
14. MOTHER'S MAIDEN NAME: Martha Ellen Truitt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-03-1473
17. INFORMANT: Address: Mrs. Bernice H. Freeny, Centreville, Md. 21617

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gram negative Bacteremia — INTERVAL BETWEEN ONSET AND DEATH: < 72 Hours
610X
DUE TO (b): Urinary tract infection — Uncertain
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Obstructive uropathy due to Benign prostatic Hypertrophy

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-24, 1967, to 5-15, 1967, that (I) (we) last saw the deceased alive on 5-14 1967, and that death occurred at 7:35 A M, from causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): BURIAL
23b. DATE THEREOF: May 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City or Town) (County) (State): Salisbury Wicomico Co Md.
24. FUNERAL DIRECTOR: James H. Barton Jr - Barton Bros. — ADDRESS: Centreville, Md.
25a. REC'D BY REGISTRAR DATE: MAY 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07263

# CERTIFICATE OF DEATH

07243

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 21 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 302 N. Washington Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: 302 N. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: Howard — Last: Gardner, Sr.

4. DATE OF DEATH: Month: May — Day: 16 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12.23/1887

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Talbot Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bennett Gardner

14. MOTHER'S MAIDEN NAME: Laura V. Jarrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-30-8678

17. INFORMANT — Address: Mrs. ~~Xxxxxx~~ Gertrude Kilmon, Easton, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b): Coronary Arteriosclerosis — Syrs.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/1, 1967, to 5/16, 1967, that (I) (~~this hospital~~) last saw the deceased alive on 2/15 1967, and that death occurred at 6:38 P.M., from causes and on the date stated above.

22a. SIGNATURE: Robert M. McDonald — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/17/67

22c. PHYSICIAN'S NAME (Type): Robert M. McDonald, M.D.

22d. ADDRESS: South Hanson St., Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/19/1967

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial Park

23d. LOCATION (City or Town) (County) (State): Easton, Md.

24. FUNERAL DIRECTOR — ADDRESS: MAURICE E. NEWNAM & SON, Easton, Md.

25a. REC'D BY REGISTRAR DATE: MAY 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

07264

## CERTIFICATE OF DEATH

07244

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: TALBOT
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 8yrs. 11Mo- 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOUSE IN THE PINES - EASTON, MD.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denton, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: MARY Middle: FRANCES Last: GARTON

4. **DATE OF DEATH**: Month: MAY Day: 5 Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/26/1884

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN H. HORSEY

14. MOTHER'S MAIDEN NAME: ANNA PENNINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: HARRY COPELAND, 4663 MALDEN DR. WIL. DEL

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days

331X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July, 1964 to 5 May, 1967, that (I) (was) last saw the deceased alive on 2 May 1967, and that death occured at 1:30A M, from the causes and on the date stated above.

22a. SIGNATURE: Stephen P Carney M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-5-67

22c. PHYSICIAN'S NAME (Type): Stephen P. Carney, M.D.

22d. ADDRESS: P.O. Box 929, Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: DENTON

23d. LOCATION (City, town or county): DENTON (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Charles W. Moore

ADDRESS: Denton

25a. REC'D BY REGISTRAR DATE: MAY 11 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07265

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 40 am 07245

1. **PLACE OF DEATH**
   a. COUNTY: TALBOT — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD.
   b. COUNTY: TALBOT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOZMAN
   d. STREET ADDRESS: RFD-
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: LEVIN D. — Middle: GRACE — Last:

4. **DATE OF DEATH**: Month: 5 — Day: 15 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 3, 1892

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD. TALBOT

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES BAILEY

14. MOTHER'S MAIDEN NAME: KATIE BAILEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
   (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 217-03-5472A

17. **INFORMANT** Address: JACOB GRACE, JR. SHERWOOD, MD.

### MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Ruptured arteriosclerotic interthoracic aneurysm
   451X
   DUE TO (b):
   DUE TO (c):
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
   INTERVAL BETWEEN ONSET AND DEATH:

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis O'Neill M.D.

EXAMINER'S NAME (Type): WELTON

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 5-20-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 20-67

23c. NAME OF CEMETERY OR CREMATORY: SHERWOOD

23d. LOCATION (City or Town) (County) (State): SHERWOOD-TALBOT MD

24. FUNERAL DIRECTOR: C. H. DASHIELL — ADDRESS: EASTON, MD.

25a. REC'D BY REGISTRAR ON: MAY 24 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item #1 Film #G3885715767 pc

07266

Items #6 & 11 Film #G3885712767 pc

07246

1. PLACE OF DEATH
a. COUNTY: TALBOT
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 3 days 7½ hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
d. STREET ADDRESS: 20-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ROSA Middle ELLA Last HAWKINS

4. DATE OF DEATH: Month 5 Day 3 Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-20-1894

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR Months ___ Days ___ IF UNDER 24 HRS. Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Talbot Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES WARRICK

14. MOTHER'S MAIDEN NAME: ONIE DA WARRICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-09-1357

17. INFORMANT: CHARLES HAWKINS Address: EASTON, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): RESPIRATORY PARALYSIS — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

1930

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): METASTATIC BRAIN CANCER — 1 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): LEIOMYOSARCOMA BLADDER, DIBETES

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-1, 1966, to 5-3, 1967, that (I) (we) last saw the deceased alive on 5-3 1967, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard Tyson — ATTENDING M.D. PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-5-67

22c. PHYSICIAN'S NAME (Type): RICHARD TYSON

22d. ADDRESS: EASTON Md 21601

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried

23b. DATE THEREOF: 5-7-67

23c. NAME OF CEMETERY OR CREMATORY: New Town

23d. LOCATION (City, town or county) (State): AT-P Cordova, Md

24. FUNERAL DIRECTOR: George H Dashiell Easton Md

ADDRESS:

25a. REC'D BY REGISTRAR DATE: MAY 9 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07267 — 07247

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 4 Da.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ST. MICHAELS 20.1
d. STREET ADDRESS: TALBOT ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alfred Middle: Otho Last: Herman

4. DATE OF DEATH: Month: 5 Day: 13 Year: 1967

5. SEX: ~~WHITE~~ MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN 31, 1884

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst Gen Mgr-East Lines

10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R.

11. BIRTHPLACE (County & State, or foreign country): San Francisco, Cal.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred Herman

14. MOTHER'S MAIDEN NAME: Delia Little

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)

16. SOCIAL SECURITY NO.: 705-03-1749

17. INFORMANT: Mrs. Amy C. Herman, Address: St. Michaels, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Arteriosclerotic Cardiovascular
DUE TO (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443 x
INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 5-9, 1967, to 5-13, 1967, that (I) ~~(we)~~ last saw the deceased alive on 5-13, 1967, and that death occurred at 12:30 A M, from causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/15/67

22c. PHYSICIAN'S NAME (Type): R. Lane Wroth M.D.

22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 16, 1967

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Easton, Maryland

24. FUNERAL DIRECTOR: Harrison Leonard

ADDRESS: St. Michaels, Md.

25a. REC'D BY REGISTRAR DATE: MAY 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #5 Film #G389 6/12/67 pc

07268

## CERTIFICATE OF DEATH

07248

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 6 d.a.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Memorial Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: MD. b. COUNTY: QUEEN ANNE
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): STEVENSVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adell Middle: Conley Lost: Hines

4. DATE OF DEATH: Month: 5 Doy: 27 Year: 1967

5. SEX: Female F

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-20-1893

9. AGE (In yeors lost birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): QUEEN ANNE

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES CONLEY

14. MOTHER'S MAIDEN NAME: ANNIE GREEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: John Hines - Stevensville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5-21-67
DUE TO
(b): Cerebral arteriosclerosis — Uncertain
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive an _____ 19__, and that death accurred at 12:30 P M, from causes and an the date stated above.

22o. SIGNATURE: Robert W. Trever M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/27/67

22c. PHYSICIAN'S NAME (Type): Robert W. Trever M.D.

22d. ADDRESS: Easton, Maryland 5/27/67

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-31-67

23c. NAME OF CEMETERY OR CREMATORY: STEVENSVILLE

23d. LOCATION (City or Town) (County) (State): STEVENSVILLE - QUEEN ANNE MD.

24. FUNERAL DIRECTOR: Leary & Dorsey ADDRESS: Easton Md

25o. REC'D BY REGISTRAR DATE: JUN 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07263 Items #8 & 9 Film #0388 5/12/67 pc 07249

1. PLACE OF DEATH
a. COUNTY TALBOT
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON
c. LENGTH OF STAY IN 1b 7 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY QUEEN ANNE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester Town
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Lloyd Middle Lorenzo Last Holden
4. DATE OF DEATH Month 5 Day 3 Year 1967
5. SEX MALE
6. COLOR OR RACE NEGRO
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12/28/02
9. AGE (In years last birthday) UNKNOWN Yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY WATERMAN
11. BIRTHPLACE (County & State, or foreign country) CRISFIELD, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME UNKNOWN
14. MOTHER'S MAIDEN NAME UNKNOWN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) UNKNOWN (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 219-01-0899
17. INFORMANT Address Mrs. FLORENCE WRIGHT, CHESTER, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure
525X
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cor pulmonale
DUE TO (c) Pulmonary fibrosis
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) this hospital attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that death occurred at 8:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE E.C.H. Schmidt M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED 3 May 67
22c. PHYSICIAN'S NAME (Type) E.C.H. Schmidt
22d. ADDRESS Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 5-6-67
23c. NAME OF CEMETERY OR CREMATORY CHESTER CEMETERY
23d. LOCATION (City, town or county) (State) CHESTER, MARYLAND
24. FUNERAL DIRECTOR Dashiell Funeral Home ADDRESS
25a. REC'D BY REGISTRAR DATE MAY 9 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

**MARYLAND STATE DEPARTMENT OF HEALTH**
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

# CERTIFICATE OF DEATH

07270 07250

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels (Rural)
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rio Vista Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tilghman 20.1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle H. Last Jackson
4. DATE OF DEATH: Month May Day 9 Year 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 20, 1880
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Talbot Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William P. Jackson
14. MOTHER'S MAIDEN NAME: Unkn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): no
16. SOCIAL SECURITY NO.: 217-36-1304
17. INFORMANT Address: Mrs. William H. Russell, Tilghman, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b): Arteriosclerotic Vascular Dis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332X
INTERVAL BETWEEN ONSET AND DEATH: 2 days / 7 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Dec, 19 66, to May 9, 1967, that (I) (~~we~~) last saw the deceased alive on May 1967 and that death occurred at 6:30 AM, from causes and on the date stated above.

22a. SIGNATURE: R. Paul Wroth M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-9-67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/11/1967
23c. NAME OF CEMETERY OR CREMATORY: Jackson Cemetery
23d. LOCATION (City or Town) (County) (State): Tilghman, Md.

24. FUNERAL DIRECTOR ADDRESS: MURICE E. NEWNAM & SON, Easton, Md.

25a. REC'D BY REGISTRAR DATE: MAY 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07271

## CERTIFICATE OF DEATH

07251

1. PLACE OF DEATH
a. COUNTY Talbot
MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) EASTON
c. LENGTH OF STAY IN 1b 3 1/2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD.
b. COUNTY TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRAPPE
d. STREET ADDRESS 201
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Frances Middle Last Jenkins

4. DATE OF DEATH Month 5 Day 14 Year 1967

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 9-15-1904
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY Cook
11. BIRTHPLACE (County & State, or foreign country) TALBOT MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Prince Small
14. MOTHER'S MAIDEN NAME Ella Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO
16. SOCIAL SECURITY NO. 133-03-3989
17. INFORMANT Address Marie Bowen Phila. PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Hrs
DUE TO (b) Congestive Heart Failure — Years
DUE TO (c) Arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension and Bronchial Asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) this hospital attended the deceased from 5-12, 1967 to 5-14, 1967, that (I) (we) last saw the deceased alive on 5-14 1967 and that death occurred at 12:45 M, from causes and on the date stated above.

22a. SIGNATURE Richard Tyson M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 5-15-67
22c. PHYSICIAN'S NAME (Type) RICHARD TYSON
22d. ADDRESS EASTON Md 21601

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 5-17-67
23c. NAME OF CEMETERY OR CREMATORY SCREAMERSVILLE
23d. LOCATION (City or Town) (County) (State) OXFORD TALBOT MD

24. FUNERAL DIRECTOR ADDRESS Geo. H. Pabst Easton md
25a. REC'D BY REGISTRAR DATE MAY 24 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07272 Item #2 infor, taken from birth cert

## CERTIFICATE OF DEATH

07252

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| | |
|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY: Talbot<br>MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON<br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE: Md. b. COUNTY: Talbot<br>c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Tilghman 20.1<br>d. STREET ADDRESS: P.O. Box 223<br>e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ |
| 3. NAME OF DECEASED (Type or print): First: Baby Middle: Girl Last: Johnson | 4. DATE OF DEATH: Month: 5 Day: 21 Year: 1967 |
| 5. SEX: Female<br>6. COLOR OR RACE: White<br>7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐<br>8. DATE OF BIRTH: 5/21/67<br>9. AGE (In years last birthday): N.B. yrs.<br>IF UNDER 1 YEAR: Months / Days<br>IF UNDER 24 HRS.: Hours: 14 Min.: 10 | |
| 10a. USUAL OCCUPATION (Give kind of wark dane during most of warking life, even if retired)<br>10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (Caunty & State, ar foreign country)<br>12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME: Charles W. Johnson, Sr.<br>14. MOTHER'S MAIDEN NAME: Nellie Hilditch | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)<br>16. SOCIAL SECURITY NO.<br>17. INFORMANT Address: Mrs. Charles W. Johnson, Tilghman, Md. | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immediately — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
776X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Haur o.m. p.m. 19

20d. INJURY OCCURRED While at wark ☐ Nat While at wark ☐

20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)

20f. (City ar town) (Caunty) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-2, 1967, to 5-21, 1967, that (I) (we) last saw the deceased alive on 5-21, 1967, and that death occurred at 00 M, from causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-23-67.

22c. PHYSICIAN'S NAME (Type): R. Lane Wroth M.D.

22d. ADDRESS: St. Michaels, Maryland 5/23/67

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE THEREOF: 5/23/1967 | 23c. NAME OF CEMETERY OR CREMATORY: Methodist Cemetery | 23d. LOCATION (City or Town): Tilghman, Md. (County) (State) | |
| 24. FUNERAL DIRECTOR: Maurice F. Dennemann-Son | ADDRESS: Easton Md | 25a. REC'D BY REGISTRAR DATE: MAY 26 1967 | 25b. REGISTRAR'S SIGNATURE: Peter Judge | |

7-227036

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07273

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07253

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Talbot Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tilghman
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles William — Middle — Last Johnson, Sr.

4. DATE OF DEATH: Month May — Day 9 — Year 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/29/1926

9. AGE (In years last birthday): 40 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator

10b. KIND OF BUSINESS OR INDUSTRY: Feed Mill

11. BIRTHPLACE (State or foreign country): South Port, N.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wesley Johnson

14. MOTHER'S MAIDEN NAME: Lizzie Hewett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): 1/44 - 2/45

16. SOCIAL SECURITY NO.: 242-32-0168

17. INFORMANT: Mrs. Charles W. Johnson — Address: Tilghman, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction due to — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Atherosclerotic coronary thrombosis — sudden
DUE TO
(c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Thurston Harrison M.D.

EXAMINER'S NAME (Type): THURSTON HARRISON

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 12 May 67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/12/1967

23c. NAME OF CEMETERY OR CREMATORY: Methodist Cemetery

23d. LOCATION (City or Town) (County) (State): Tilghman, Md.

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON — ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: MAY 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15ME (5) 6M 1/67

1

(M)

**MARYLAND STATE DEPARTMENT OF HEALTH**
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

# CERTIFICATE OF DEATH

07274 — 07254

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

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**1. PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 7 hours.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: QUEEN ANNE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PRICE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Mrs. Louise — Middle: Hill — Last: Kimble

**4. DATE OF DEATH**: Month: 5 — Day: 31 — Year: 67

**5. SEX**: FEMALE

**6. COLOR OR RACE**: WHITE

**7. MARRIED** ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

**8. DATE OF BIRTH**: 3-27-1918

**9. AGE** (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY**: XX

**11. BIRTHPLACE** (County & State, or foreign country): CAROLINE Co. MARYLAND

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: JEFF HILL

**14. MOTHER'S MAIDEN NAME**: NELLIE OUTTEN

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT** — Address: DUDLEY KIMBLE - PRICE MD.

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**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 HRS
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from 30 may, 1967 to 31 may, 1967 that (I) (~~we~~) last saw the deceased alive on 30 may 1967, and that death occurred at 4:25 AM, from causes and on the date stated above.

**22a. SIGNATURE**: Stephen P Carney — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 6-2-67

**22c. PHYSICIAN'S NAME (Type)**: Stephen P. Carney M.D.

**22d. ADDRESS**: Easton, Maryland 6/2/67

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**23a. BURIAL, CREMATION, REMOVAL (Specify)**: BURIAL

**23b. DATE THEREOF**: JUNE 2

**23c. NAME OF CEMETERY OR CREMATORY**: CHURCH HILL

**23d. LOCATION** (City or Town) (County) (State): CHURCH HILL MD.

**24. FUNERAL DIRECTOR**: Edgar L. Lane — ADDRESS: Church Hill Md.

**25a. REC'D BY REGISTRAR** — DATE: JUN 6 1967

**25b. REGISTRAR'S SIGNATURE**: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

07275 07255

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

**1. PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 4/5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Easton rural
d. STREET ADDRESS: 20.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Colvin — Middle: H.C. — Last: Kirby

**4. DATE OF DEATH**: Month: 5 — Doy: 23 — Year: 1967

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 12/20/1910

**9. AGE** (In yeors last birthdoy): 56 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): salesman

**10b. KIND OF BUSINESS OR INDUSTRY**: gas

**11. BIRTHPLACE** (County & State, or foreign country): Talbot, Maryland

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Frank I. Kirby

**14. MOTHER'S MAIDEN NAME**: Mazie Lambdin

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give wor or dotes of service): no

**16. SOCIAL SECURITY NO.**: 213-09-9772

**17. INFORMANT** Address: Mrs. Emma Elizabeth Kirby, Easton, M

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple pulmonary emboli — INTERVAL BETWEEN ONSET AND DEATH
576X
DUE TO (b): Pelvic thrombosis
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c): ~~Peritonitis~~ Peritonitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Massive infarction small bowel & resection

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter noture of injury in Port I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Doy, Yeor Hour o.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, form, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on _____, 19__, and that death occurred at 5:10 P.M. from causes and on the date stated above.

**22a. SIGNATURE**: E.C.H. Schmidt — M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**: 23 May 67

**22c. PHYSICIAN'S NAME** (Type): E.C.H. Schmidt

**22d. ADDRESS**: Easton, Maryland

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 5/25/67

**23c. NAME OF CEMETERY OR CREMATORY**: Woodlawn Memorial Park

**23d. LOCATION** (City or Town) (County) (State): Easton, Talbot, Md.

**24. FUNERAL DIRECTOR** — **ADDRESS**: Jay D. Heuerin F.H. Easton, Md.

**25a. REC'D BY REGISTRAR** DATE: MAY 25 1967

**25b. REGISTRAR'S SIGNATURE**: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

07276

## CERTIFICATE OF DEATH

07256

**1. PLACE OF DEATH**
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 1yr. 6mo. 17days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): HOUSE IN THE PINES * EASTON, MD.

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: 401 S. Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: ELIZABETH Bean — Middle: — Last: KLEPPINGER

**4. DATE OF DEATH**: Month: 5 — Day: 3 — Year: 19 67

**5. SEX**: FEMALE

**6. COLOR OR RACE**: WHITE

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 2-19-81

**9. AGE** (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housework

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Pa.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Hiriam Halteman

**14. MOTHER'S MAIDEN NAME**: Elizabeth Bean

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no — (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: 180-10-8682

**17. INFORMANT** Address: D Mrs. Mabel Kleppinger, Easton, Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Septicemia | 5 days |
| 6000 DUE TO (b) | acute and chronic pyelitis + pyelonephritis | 2 yrs. |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19 — **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ — **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from 19 Dec, 1967, to 3 May, 1967, that (I) (we) last saw the deceased alive on 2 May 1967, and that death occured at 7 A.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Stephen P Carney M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 5-3-67

**22c. PHYSICIAN'S NAME** (Type): Stephen P. Carney, M.D.

**22d. ADDRESS**: P.O. Box 929, Easton, Md. 21601

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Removan, Burial — **23b. DATE THEREOF**: 5/6/1967 — **23c. NAME OF CEMETERY OR CREMATORY**: Union Cemetery — **23d. LOCATION** (City, town or county) (State): Macungie, Pa.

**24. FUNERAL DIRECTOR'S SIGNATURE**: Maurice E. Neumansom — **ADDRESS**: Easton, Md.

**25a. REC'D BY REGISTRAR** DATE: MAY 5 1967 — **25b. REGISTRAR'S SIGNATURE**: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07278

## CERTIFICATE OF DEATH

07257

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

**1. PLACE OF DEATH**
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 17 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Hill
d. STREET ADDRESS: RT-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: Olen Middle: Leonard Last: Mollock

**4. DATE OF DEATH**: Month: 5 Day: 25 Year: 1967

**5. SEX**: M

**6. COLOR OR RACE**: Negro

**7. MARRIED** ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: OCT. 2 1904

**9. AGE** (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Minister

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Vienna Md.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: Martin Mollock

**14. MOTHER'S MAIDEN NAME**: Eldora Jones

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service): No

**16. SOCIAL SECURITY NO.**: 188-07-5521

**17. INFORMANT** Address: Leah Mollock Upper Hill Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage from Rt. Middle Cerebral Artery — INTERVAL BETWEEN ONSET AND DEATH: 2 days
331X
DUE TO (b): Hypertensive and Atherosclerotic
DUE TO (c): Cerebral Vascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year Hour a.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21.** I certify thot (I) (this hospital) attended the deceased from 5/24, 1967 to 5/25, 1967 thot (I) (we) last saw the deceased alive on 5/25 1967, and thot death occurred at 10:50 A.M., from causes and on the date stated above.

**22a. SIGNATURE**: S. Krech

M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 5/26/67

**22c. PHYSICIAN'S NAME** (Type): S. KRECH, JR.

**22d. ADDRESS**: EASTON, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 5/28/67

**23c. NAME OF CEMETERY OR CREMATORY**: East New Market

**23d. LOCATION** (City or Town) (County) (State): Cambridge Md.

**24. FUNERAL DIRECTOR**: Anthony E. Ward ADDRESS: Crisfield Md.

**25a. REC'D BY REGISTRAR** DATE: MAY 31 1967

**25b. REGISTRAR'S SIGNATURE**: J. Charles Jones

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07279 — 07258

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: Beechwood — 20-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: E — Last: Moore

4. DATE OF DEATH: Month: 5 — Day: 23 — Year: 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/25/1880
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Avalon, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Moore
14. MOTHER'S MAIDEN NAME: Mollie Ann Paush

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 479-01-0472
17. INFORMANT: Mrs. Frank Russell, Easton, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumatosis — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b): Carcinoma of Pharynx — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 148X
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 20 May, 1967 to 23 May, 1967, that (I) (~~we~~) last saw the deceased alive on 23 May 1967, and that death occurred at 12 p M, from causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-25-67
22c. PHYSICIAN'S NAME (Type): R. Lane Wroth, M.D.
22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Removal
23b. DATE THEREOF: 5/25/1967
23c. NAME OF CEMETERY OR CREMATORY: Parkwood
23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: Maurice E. Newman & Son — ADDRESS:
25a. REC'D BY REGISTRAR DATE: MAY 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove [illegible] papers. Pages 1 (and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G389 6/5/67 mc

07280

# CERTIFICATE OF DEATH

07259

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN this: 3 days Hsp
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEAVITT
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph Middle: Nelligan Last: Nelligan
4. DATE OF DEATH: Month: 5 Day: 26 Year: 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JAN 7, 1900
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. BUS DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: PUB SERVICE
11. BIRTHPLACE (County & State, or foreign country): IRELAND
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: UNK
14. MOTHER'S MAIDEN NAME: KATHLEEN MURPHY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOSEPH NELLIGAN, Address: EAST ORANGE, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma of Liver — INTERVAL BETWEEN ONSET AND DEATH: 4 wks.
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
1561

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 23 May, 19 67, to 23 May, 19 67, that (I) (~~we~~) last saw the deceased alive on 5-26 19 67, and that death occurred at 6 P M, from causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-27-67
22c. PHYSICIAN'S NAME (Type): R. Lane Wroth, M. D.
22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: JUN 1, 1967
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN
23d. LOCATION (City or Town) (County) (State): EAST HANOVER, N. J.

24. FUNERAL DIRECTOR: Harmon E. Leonard
ADDRESS: St. Michaels, Md.

25a. REC'D BY REGISTRAR DATE: MAY 31 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G389 6712 767 pc

Item #1d Film #G389 6/0767 pc

07281

## CERTIFICATE OF DEATH

07260

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 22 S. Higgins St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cordova
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Estelle — Middle: Downs — Last: Newman

4. DATE OF DEATH: Month: May — Day: 30 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-14-1894

9. AGE (In years last birthday): 72 7/4 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Talbot Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Annie Downs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-14-1204

17. INFORMANT: Hilda Peterson — Address: New Brunswick, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Natural causes — INTERVAL BETWEEN ONSET AND DEATH: 1 day
   DUE TO (b):
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   7955

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 23, 1963 to May 29, 1967, that (I) (we) last saw the deceased alive on May 30 1967, and that death occurred at 4:00 P.M., from causes and on the date stated above.

22a. SIGNATURE: Dale R. Kollman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-5-67

22c. PHYSICIAN'S NAME (Type): Dale R. Kollman, MD

22d. ADDRESS: Easton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-5-1967

23c. NAME OF CEMETERY OR CREMATORY: Chapel

23d. LOCATION (City or Town) (County) (State): Chapel Talbot Md.

24. FUNERAL DIRECTOR: G. H. DASHIELL — ADDRESS: Easton, MD

25a. REC'D BY REGISTRAR DATE: JUN 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07282

# CERTIFICATE OF DEATH

07261

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
d. STREET ADDRESS: 706 High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): FIRST EDWARD — MIDDLE RICHARD — Middle X — Last SR RENSHAW

4. DATE OF DEATH: Month 5 — Day 1 — Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 8-13-03

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months 8 — Days 18
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MECHANIC

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or foreign country): TALBOT COUNTY-MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: HARVEY M. RENSHAW

14. MOTHER'S MAIDEN NAME: LAURA ANNA GRUBB

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: 212-01-8186

17. INFORMANT — Address: MRS. E. RICHARD RENSHAW, SR. EASTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Metastatic carcinoma of
163X
DUE TO (b): the lung
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (o), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Uncertain

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): Pulmonary emphysema (chronic obstructive)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospitol) attended the deceased from _____, 19__, to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 6:45 P M, from causes and on the dote stated obave.

22a. SIGNATURE: Robert W. Trever M.D. — ATTENDING PHYS. ☐ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Robert W. Trever, MD.

22d. ADDRESS: Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: MAY 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: SPRING HILL

23d. LOCATION (City or Town) (County) (State): EASTON TALBOT MARYLAND

24. FUNERAL DIRECTOR: [signature] — ADDRESS: Easton Md

25a. REC'D BY REGISTRAR DATE MAY 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Junge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07283

## CERTIFICATE OF DEATH

07262

1. **PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxford
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxford
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Lillie — Middle: May — Last: Richardson

4. **DATE OF DEATH**: Month: May — Day: 11 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/29/1882

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Talbot Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Cottingham

14. MOTHER'S MAIDEN NAME: Ida Corkran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-32-0122

17. **INFORMANT**: B Jesse F. Richardson, Oxford, Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Arteriosclerosis — 5 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Nov, 19 66, to 5/11, 19 67, that (I) saw the deceased last saw the deceased alive on 5/11 19 67, and that death occurred at 11 M, from causes and on the date stated above.

22a. SIGNATURE: Robert M. McDonald — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/12/67

22c. PHYSICIAN'S NAME (Type): ROBERT M. McDONALD, M.D.

22d. ADDRESS: 3 Hanson St. Easton, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/14/1967

23c. NAME OF CEMETERY OR CREMATORY: Oxford

23d. LOCATION (City or Town) (County) (State): Oxford, Md.

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON — ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: MAY 15 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

**MARYLAND STATE DEPARTMENT OF HEALTH**
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

# CERTIFICATE OF DEATH

07284 — 07263

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels (rural)
c. LENGTH OF STAY IN Tb: 1 year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rio Vista Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 5107 Wesley Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Christie — Middle: I. — Last: Rowlenson
4. DATE OF DEATH: Month: May — Day: 31 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/3/1885
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Talbot Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Howeth
14. MOTHER'S MAIDEN NAME: Charlotte E. Covington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 220-54-6498
17. INFORMANT — Address: Richard F. Rowlenson, HavredeGrace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): chronic cardiac failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. — DUE TO (c):
493X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): pneumonia - Terminal
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-25, 1946, to 5-30, 1967, that (I) (we) last saw the deceased alive on 5-30 19 67 and that death occurred at 11:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-2-67
22c. PHYSICIAN'S NAME (Type): Roy M Reese Jr
22d. ADDRESS: St Michaels md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/2/1967
23c. NAME OF CEMETERY OR CREMATORY: Methodist Cemetery
23d. LOCATION (City or Town) (County) (State): Tilghman, Md.

24. FUNERAL DIRECTOR — ADDRESS: MAURICE E. NEWNAM & SON, Easton, Md.
25a. REC'D BY REGISTRAR — DATE: JUN 5 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
25M 1/67

Item 18 Film 389 6-19

# MARYLAND STATE DEPARTMENT OF HEALTH

**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07285 — 07264

1 FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

1. **PLACE OF DEATH** — a. COUNTY: Talbot — MARYLAND; b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Easton, R.D.; c. LENGTH OF STAY IN 1b:; d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland; b. COUNTY: Dorchester; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge; d. STREET ADDRESS: 422 Glenburn Ave.; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William; Middle: Neill; Last: Smith

4. **DATE OF DEATH**: Month: May; Day: 6; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Aug. 2, 1923

9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cambridge

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Marcus Duke Smith, M.D.

14. MOTHER'S MAIDEN NAME: Mabel Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — If yes give war or dates of service): W.W. 2

16. SOCIAL SECURITY NO.:

17. INFORMANT: M. Edward Smith, Round Bay, Severna Park, Address 10 Luna Lane

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute alcoholism — INTERVAL BETWEEN ONSET AND DEATH:
3220
DUE TO (b):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis Welty, M.D.

EXAMINER'S NAME (Type): Louis Welty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 5-8-67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 8, 1967

22c. NAME OF CEMETERY OR CREMATORY: Cambridge Cemetery

22d. LOCATION (City, town, or county): Cambridge, Md. (State):

23. FUNERAL DIRECTOR: Kenneth R. Thomas — ADDRESS: Cambridge, Md.

24a. REC'D BY REGISTRAR (DATE): MAY 9 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07286 — 07265

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 509 Pleasant Place

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton — 20.1
d. STREET ADDRESS: 509 Pleasant Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: Stratton — Last: Stewart
4. DATE OF DEATH: Month: May — Day: 8 — Year: 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 26, 1908
9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tariff Publisher
10b. KIND OF BUSINESS OR INDUSTRY: Interstate Trucking
11. BIRTHPLACE (County & State, or foreign country): Phila. Pa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David R. Stewart
14. MOTHER'S MAIDEN NAME: Rebecca M. Stratton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 067-07-2716
17. INFORMANT: Address: Mrs. David S. Stewart, Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: Instant
H200
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — 10 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Myocardial infarction 2-20-67
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 27 Dec, 1963, to 8 May, 1967, that (I) (~~we~~) last saw the deceased alive on 28 Apr 1967, and that death occurred at 11¾ M, from the causes and on the date stated above.

22a. SIGNATURE: Stephen P. Carney — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-9-67
22c. PHYSICIAN'S NAME (Type): Stephen P. Carney, M.D.
22d. ADDRESS: P.O. Box 929, Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal Burial
23b. DATE THEREOF: 5/11/1967
23c. NAME OF CEMETERY OR CREMATORY: Greenfield Cemetery
23d. LOCATION (City, town or county) (State): Hempstead, N.Y.
24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON — ADDRESS: Easton, Md.
25a. REC'D BY REGISTRAR DATE: MAY 11 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23d Film c389 5/26/67 kk

## CERTIFICATE OF DEATH

07287 — 07266

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

**1. PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 24 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Annes
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville 21617
d. STREET ADDRESS: 113 Glendale Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: Gladys — Middle: Pilling — Last: VANOrsdale

**4. DATE OF DEATH**: Month: 5 — Day: 23 — Year: 1967

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: October 23, 1901

**9. AGE** (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Wife

**10b. KIND OF BUSINESS OR INDUSTRY**: Home

**11. BIRTHPLACE** (County & State, or foreign country): Busti Chautauqua Co, N.Y.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Henry Pilling

**14. MOTHER'S MAIDEN NAME**: Edna Demming

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: 134-05-0723

**17. INFORMANT**: Husband — Address: Ralph R VANOrsdale, Centreville, Md.

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral thrombosis with hemi- — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(b): plegia — 48 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c): Cerebral arteriosclerosis — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Laennec's cirrhosis with ascites

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**MEDICAL CERTIFICATION**

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. — 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21.** I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 1:25 P.M., from causes and on the date stated above.

**22a. SIGNATURE**: Robert W. Trever — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): Robert W. Trever, M.D.

**22d. ADDRESS**: Easton, Maryland

**23a. BURIAL, ~~CREMATION~~, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF**: MAY 26, 1967

**23c. NAME OF CEMETERY OR CREMATORY**: Woodlawn Cemetery

**23d. LOCATION** (City or Town) (County) (State): East Hamburg, Co. of Erie, NY

**24. FUNERAL DIRECTOR**: James H. Burton Jr - Burton Bros. — ADDRESS: Centreville, Md.

**25c. REC'D BY REGISTRAR** DATE: MAY 26 1967

**25b. REGISTRAR'S SIGNATURE**: J. Charles Judge

1

FOR STATE HEALTH DEPT. IVI

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DOA 1:30 pm

07288

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07267

1. PLACE OF DEATH
   a. COUNTY: TALBOT
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD.
   b. COUNTY: QUEEN ANNE
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): GRASONVILLE
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: TROY Middle: FRANKLIN LEWELLIN Last: WASHINGTON

4. DATE OF DEATH: Month: MAY Day: 8 Year: 1967

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-8-1965

9. AGE (In years last birthday): 2 yrs.
   IF UNDER 1 YEAR: Months: 3 Days:
   IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES V. BOARDLEY

14. MOTHER'S MAIDEN NAME: BARBARA JEAN WASHINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: BARBARA JEAN WASHINGTON Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH:
   DUE TO (b): Patent Ductus Arteriosus
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Ex Status medea

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: C R Layton M.D.

EXAMINER'S NAME (Type): C. R. Layton

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county): Centreville Md

22. DATE SIGNED: 5-11-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-11-67

23c. NAME OF CEMETERY OR CREMATORY: BATTS NECK

23d. LOCATION (City or Town) (County) (State): BATTS NECK QUEEN ANNE MD

24. FUNERAL DIRECTOR: G. H. DASHIELL ADDRESS: EASTON, MD

25a. REC'D BY REGISTRAR DATE: MAY 15 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07283

## CERTIFICATE OF DEATH

07268

1. **PLACE OF DEATH**
   a. COUNTY: Talbot
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN THIS PLACE: 60 DA.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD.
   b. COUNTY: TALBOT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OXFORD
   d. STREET ADDRESS: MARKET ST. 201
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: James Middle: Edward Last: WILSON

4. **DATE OF DEATH**: Month: 5 Day: 17 Year: 1967

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-1-1888

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (County & State, or foreign country): TALBOT, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ROBERT WILSON

14. MOTHER'S MAIDEN NAME: MARY BENTLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-30-8862

17. **INFORMANT**: MARGARET BANKS Address: OXFORD, MD.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Obstructive uropathy
DUE TO (c): Benign prostatic hypertrophy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 610X

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 9:45 A M, from causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever
M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/19/67

22c. PHYSICIAN'S NAME (Type): Robert W. Trever M.D.

22d. ADDRESS: Easton, Maryland 5/19/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-22-1967

23c. NAME OF CEMETERY OR CREMATORY: TRAPPE

23d. LOCATION (City or Town) (County) (State): TRAPPE - TALBOT MD

24. FUNERAL DIRECTOR ADDRESS: Dashiell Funeral Home

25a. DATE RECD BY REGISTRAR: MAY 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07290

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07269

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): DENTON RD 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle ROGER — Last WRIGHT

4. DATE OF DEATH: Month MAY — Day 24 — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: FEB. 5, 1875

9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOHN WESLEY WRIGHT

14. MOTHER'S MAIDEN NAME: DEMORETT HENRIETTA BELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: HOSP. RECORDS 1951 TO DATE

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): INTESTINAL OBSTRUCTION
DUE TO (b): CA OF COLON
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
1538
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
ANESTHESIA PRIOR TO OPERATION—NO OPERATION PERFORMED

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
R.C. 10:43 A.M.

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** thot I took charge of the remoins described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Naturol causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Louis Welty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
FOR DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): WELTY
Address (Street, city, town, or county):

22. DATE SIGNED: 5-25-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: May 28, 1967
23c. NAME OF CEMETERY OR CREMATORY: BELLS CHAPEL
23d. LOCATION (City or Town) (County) (State): CAROLINE, MD.

24. FUNERAL DIRECTOR: Charles L. Moore — ADDRESS: Denton Md.

24a. REC'D BY REGISTRAR DATE: MAY 29 1967

25. REGISTRAR'S SIGNATURE: Charles Judge